Thomas K. Koithan, P.C.
IMPORTANT FINANCIAL INFORMATION
Please Read Carefully

Authorization for Services

Our clinicians participate with various HMO's, PPO's and other managed-care organizations. Some of these plans require preauthorization before the first visit. I understand it is my responsibility to obtain this authorization. Mental health benefits may differ from medical benefits so it is essential that I have researched my mental health benefits prior to my visit. If I have not done this prior to my visit and/or treatment is not a payable benefit, I will be responsible for the full payment at the time of service. Further, if my insurance carrier determines that the services I receive are not medically necessary, I will be responsible for full payment of the bill.

Payment at the Time of Service

I understand this office's policies regarding payment for services. I will make payment in full at the time of each visit unless other arrangements have been made in advance. Insurance will be filed by the office at no charge and I will make any deductible, co-payments, or non-covered service payments at the time of service. If I must be billed there will be a $10.00 service fee.

To avoid the $10.00 service charges for billing I authorize this office to retain my credit card number. I understand that my card will be charged if my insurance pays less than expected or if payment has not been received from my insurance. Thomas K. Koithan, P.C will reimburse the excess paid upon insurance reimbursement.

MC or Visa #_____ Exp._____
Code on back of card_____
.
_____ _____ _____
Printed Name Date

Canceled or Missed Appointments

I understand that when scheduling an appointment, I am reserving professional time in advance. It is my responsibility to keep scheduled appointments. If unable to keep an appointment, I agree to provide a minimum of 24-hour notice during business hours. I acknowledge that a pattern of missed appointments constitutes grounds for unilateral termination of services. I will pay a minimum of $55.00 for all missed appointments and appointments canceled without 24-hour notice. I acknowledge that my insurance plan will not cover these fees.

Telephone Consultation

I will pay for all telephone consultations requested in lieu of a scheduled appointment or to discuss non-urgent medication or clinical concerns (minimum of $25). I understand I will not be charged for calls the clinician requested of me for updates. I acknowledge that my insurance plan will not cover these charges.

Prescription Refills

The expectation is that I will obtain prescriptions at the time of my appointment. I will pay for each prescription called into a pharmacy and/or those written in lieu of obtaining the prescriptions at the time of my appointment (minimum $15). I acknowledge that my insurance will not cover these charges.

Requests for Records

I agree to pay for any copies of records sent to other facilities, providers, or insurance companies regarding my care (minimum $35). I also agree to pay for any reports or letters requested by or sent to a third party.

Court-Related Work

If my clinician is called upon to appear in court, testify in court, or prepare reports for the court related to services received, I agree to pay for all such services.

Custody of Dependents

I understand that as the parent/guardian bringing my child for services, I am responsible for the payment of services provided to my child.

I have received a copy of this document and assign any insurance benefits to be payable to Thomas K. Koithan, P.C

Signature_____**Date** _____
(legal guardian if under 18 years)